CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

DEPENDENT CARE ASSISTANCE PLAN
ENROLLMENT FORM **FY___**

Section A – Type of Enrollment

☐ Benefits Choice Enrollment

☐ New Hire Date of Hire _____ / _____ / _____

☐ Mid-Year Enrollment **Qualifying Change in Status Code Required** (see chart in Section D) _____

I certify that the above eligible change in status event occurred on _____/_____/_____

Section B – Employee Information

Social Security Number *Last Name* *First* *Initial*

Street Address *City* *State* *Zip Code* ( ) *Home Phone*

Agency ( ) *Work Phone*

Section C – Deduction Information and Authorization

Deduction Information and Authorization - ***I authorize the State of Illinois to deduct the amount indicated below from each paycheck for my DCAP account.***

The number of deductions for semi-monthly or bi-weekly payrolls is 24.
The number of deductions for monthly payrolls is 12.

$_____ X _____ = $_____
Deduction Amt Per Pay Number of Deductions Total Annual DCAP Expenses
(Minimum = $240.00; Maximum = $5000.00)

Section D - Change in Status Code Chart

01	Adoption of dependent *
02	Marriage
03	Divorce, legal separation or annulment *
08	Judgment, decree or court order *
10	Employee commences employment
11	Employee returns to payroll (from being on a leave of absence)

13	Employee changes employment status from Part-time <50% to Full-time
14	Spouse commences employment
16	Spouse returns from leave of absence
18	Spouse changes employment status from Part-time to Full-time
21	Change in the cost of care
24	Coordination of spouse's annual benefit election period

*** Reviewed case-by-case**

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Section E – Certification Statement (Please read carefully before signing)

I understand and certify that:

- *I may not change or stop my account deposits during the plan year unless I experience a qualifying change in status.*
- *I will forfeit any unclaimed amount remaining in my account at the end of the run-out period.*
- *I understand that deductions must continue during any paid leave of absence.*
- *I intend to participate in MCAP for the entire plan year. I do not anticipate terminating state service, retiring or going on an unpaid leave of absence.*
- *I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed.*
- *I understand that services incurred after my payroll deductions or direct monthly payments (as a result of COBRA) cease, are ineligible for reimbursement.*
- *If my payroll deductions cease for any reason, I understand my participation in the program will terminate on the last day of the pay period for which a check was issued, unless I elect to continue my participation through direct payments to the FSA Unit.*
- *To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service.*

Employee Signature: _____ **Date** ____/____/_____

Please return the signed, completed form to your agency Group Insurance Representative

Section F – Agency Approval ***(To be completed by Group Insurance Representative)***

Effective Date: _____/_____/_____ Deduction Start Date: _____/_____/_____

Organizational Processing Code: _____ _____ _____ Pay Code: _____

GIR Signature: _____ Date: _____/_____/_____

Telephone ( ) _____-_____

GIR Instructions:

- Use the FSA Inquiry Screen option 1, Deduction What If Screen – Benefits Choice Enrollment; or option 2, Deduction What If Screen – Mid-Year Enrollment, to determine the correct Effective Date and Deduction Start Date.
- Forward the original to the FSA Unit at CMS and retain one copy of the form in the member's file.